Medicaid Glossary

Amount, Duration, and Scope—The phrase used to describe the Medicaid program policy under which states are allowed to limit the items and services they cover within a statutory benefit category (e.g., physician, inpatient hospital, prescription drug). Each benefit category that a state covers must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

Assignment—The Medicaid program policy under which hospitals, physicians, nursing facilities, and other providers that elect to participate in Medicaid must accept as payment in full the program's payment for an item or service delivered to a Medicaid beneficiary and may not "balance bill" or charge the beneficiary any additional amount. If the state's Medicaid program imposes nominal cost-sharing on certain categories of Medicaid beneficiaries for certain services, the providers of those services may seek payment of the allowable cost-sharing amounts directly from the beneficiary.

Beneficiary—An individual who is eligible for and enrolled in the Medicaid program in the state in which he or she resides. Millions of individuals are eligible for Medicaid but not enrolled and are therefore not program beneficiaries.

Capitation Payment—A payment made by a state Medicaid agency under a risk contract, generally to a managed care organization (MCO). The payment is made on a monthly basis at a fixed amount on behalf of each Medicaid beneficiary enrolled in the MCO. In exchange for the capitation payment, the MCO agrees to provide (or arrange for the provision of) services covered under the contract with the state Medicaid agency to enrolled Medicaid beneficiaries. See fee-for-service, MCO, Risk Contract.

Categorical Eligibility—A phrase describing Medicaid's policy of restricting eligibility to individuals in certain groups or categories, such as children, the aged, or individuals with disabilities. Certain categories of individuals—e.g., childless adults under 65 without disabilities—are generally ineligible for Medicaid regardless of the extent of their impoverishment. Individuals who fall into approved categories must also satisfy financial eligibility requirements, including income and, in most cases, resource tests imposed by the states in which they reside. See Financial Eligibility.

Categorically Needy—A phrase describing certain groups of Medicaid beneficiaries who qualify for the basic mandatory package of Medicaid benefits. There are "categorically needy" groups that states participating in Medicaid are required to cover, such as pregnant women and infants with incomes at or below 133 percent of the Federal Poverty Level (FPL). There are also "categorically needy" groups that states may at their option cover, such as pregnant women and infants with incomes above 133 percent and up to 185 percent of the FPL. Unlike the "medically needy," "categorically needy" individuals may not "spend down" in order to qualify for Medicaid. See also Medically Needy, Spend Down.

Center for Medicaid and State Operations (CMSO)—The agency within the Centers for Medicare and Medicaid Services (CMS) with responsibility for administering Medicaid and the Children's Health Insurance Program (SCHIP).

Centers for Medicare and Medicaid Services (CMS)—The agency in the Department of Health and Human Services with responsibility for administering the Medicaid, Medicare, and State Children's Health Insurance programs at the federal level. Formerly known as the Health Care Financing Administration (HCFA).

Children's Health Insurance Program (SCHIP)—Enacted in the 1997 Balanced Budget Act as Title XXI of the Social Security Act, SCHIP is a federal-state matching program of health care coverage for uninsured low-income children. In contrast to Medicaid, SCHIP is a block grant to the states; eligible low-income children have no individual entitlement to a minimum package of health care benefits. Children who are eligible for Medicaid are not eligible for SCHIP. States have the option of administering SCHIP through their Medicaid programs or through a separate program (or a combination of both). The statutory federal matching rate for SCHIP services (on average, 70 percent) is higher than that for Medicaid (on average, 57 percent), but the federal allotment to each state for CHIP services is capped at a specified amount each year. Also referred to as the State Children's Health Insurance Program (SCHIP).

Comparability—A rule of Medicaid benefits design that requires a state to offer services in the same amount, duration, and scope to one group of categorically needy individuals (e.g., poverty-related children) as it offers to another group of categorically needy individuals (e.g., elderly SSI recipients). See Amount, Duration, andScope; Categorically Needy.

Copayment—A fixed dollar amount paid by a Medicaid beneficiary at the time of receiving a covered service from a participating provider. Copayments, like other forms of beneficiary cost-sharing (e.g., deductibles, coinsurance), may be imposed by state Medicaid programs only upon certain groups of beneficiaries, only with respect to certain services, and only in nominal amounts as specified in federal regulation.

Disallowance—A determination by CMS not to provide federal Medicaid matching payments to a state in connection with an expenditure made by the state's Medicaid program because the expenditure does not meet federal requirements for matching payments. States may appeal CMS disallowances to the Departmental Appeals Board (DAB) and to federal court. See Departmental Appeals Board.

Disproportionate Share Hospital (DSH) Payments—Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining which hospitals qualify for DSH payments and how much they receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.

Dual Eligibles—A term used to describe an individual who is eligible both for Medicare and for full Medicaid coverage, including nursing home services and prescription drugs, as well as for payment of Medicare premiums, deductibles, and co-insurance. Some Medicare beneficiaries are eligible for Medicaid payments for some or all of their Medicare premiums, deductibles, and co-insurance requirements, but not for Medicaid nursing home or prescription drug benefits. See Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual.

Drug Use Review (DUR)—The program of prospective and retrospective review of prescriptions paid for by a state Medicaid program that each state is required to conduct in order to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services—One of the services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions as well as vision, hearing, and dental problems. EPSDT services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services with respect to adult beneficiaries.

Fair Hearing—Because Medicaid is an entitlement, individuals have a statutory right to appeal denials or terminations of Medicaid benefits to an independent arbiter. The fair hearing is the administrative procedure that provides this independent review with respect to individuals who apply for Medicaid and are denied enrollment, individuals enrolled in Medicaid whose enrollment is terminated, and Medicaid beneficiaries who are denied a covered benefit or service.

Federal Financial Participation (FFP)—The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States receive FFP for expenditures for services at different rates, or FMAPs, depending on their per capita incomes. FFP for administrative expenditures also varies in its rate, depending upon the type of administrative cost. See FMAP.

Federal Poverty Level (FPL)—The federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain categories of beneficiaries. Adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines, the FPL in calendar year 2001 was $14,630 for a family of 3 in 48 contiguous States and the District of Columbia, $18,290 in Alaska, and $16,830 in Hawaii.

Federal Medical Assistance Percentage (FMAP)—The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 83 percent depending upon a state's per capita income; on average, across all states, the federal government pays at least 57 percent of the costs of Medicaid. FMAPs for administrative costs vary not by state, but by function. The general FMAP for administrative costs is 50 percent; some functions (e.g., survey and certification, fraud control units) qualify for enhanced FMAPs of 75 percent or more.

Federally Qualified Health Center (FQHC)—States are required to include services provided by FQHCs in their basic Medicaid benefits package. FQHC services are primary care and other ambulatory care services provided by community health centers and migrant health centers funded under section 330 of the Public Health Service Act, as well as by "look alike" clinics that meet the requirements for federal funding but do not actually receive federal grant funds. FQHC status also applies to health programs operated by Indian tribes and tribal organizations or by urban Indian organizations.

Fee-For-Service—A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient who then submits them to the insurance company or are submitted by the provider to the patient's insurance carrier for reimbursement.

Financial Eligibility—In order to qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. Financial eligibility requirements vary from state to state and from category to category, but they generally include limits on the amount of income and the amount of resources an individual is allowed to have in order to qualify for coverage.

Formulary—States that elect to cover prescription drugs in their Medicaid programs may limit the drug products covered through the use of a formulary, a listing of the specific drugs for which a state will make payment without prior authorization. States may exclude from their formularies specific drugs of manufacturers participating in the Medicaid rebate programs only if certain criteria are met and only if the excluded drug is made available through a prior authorization program.

Freedom of Choice—Refers to both the right of providers to choose whether or not to participate in the Medicaid program and the right of Medicaid beneficiaries to choose providers from among those participating. This right with respect to beneficiaries is commonly waived in states implementing Medicaid managed care. See Waivers.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)—The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, which requires each state's Medicaid management information system (MMIS) to have the capacity to exchange data with the Medicare program and contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions relating to the processing of health claims.

Home- and Community-Based Services (HCBS) Waiver— Also known as the "1915(c) waiver" after the enabling section in the Social Security Act, this waiver authorizes169 the Secretary of HHS to allow a state Medicaid program to offer special services to beneficiaries at risk of institutionalization in a nursing facility or facility for the mentally retarded. These home and community-based services, which otherwise would not qualify for federal matching funds, include case management, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. They also include, in the case of individuals with chronic mental illness, day treatment and partial hospitalization, psychosocial rehabilitation services, and clinic services.

Intergovernmental Transfer (IGT)—The transfer of non-Federal public funds from a local government (or locally owned hospital or nursing facility) to the state Medicaid agency, or from another state agency (or state-owned hospital) to the State Medicaid agency, usually for the purpose of providing the state share of a Medicaid expenditure in order to draw down federal matching funds. Often used in connection with payments to DSH hospitals and UPL transactions. See DSH, UPL.

Mandatory—State participation in the Medicaid program is voluntary. However, if a state elects to participate, as all do, the state must at a minimum offer coverage for certain services to certain populations. These eligibility groups and services are referred to as "mandatory" in order to distinguish them from the eligibility groups and services that a state may, at its option, cover with federal Medicaid matching funds. See Optional.

Medical Assistance—The term used in the federal Medicaid statute (Title XIX of the Social Security Act) to refer to payment for items and services covered under a state's Medicaid program on behalf of individuals eligible for benefits.

Medically Needy—A term used to describe an optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses, commonly hospital or nursing home care. These individuals meet Medicaid's categorical requirements— i.e., they are children or parents or aged or individuals with disabilities—but their income is too high to enable them to qualify for "categorically needy" coverage. Instead, they qualify for coverage by "spending down"— i.e., reducing their income by their medical expenses States that elect to cover the "medically needy" do not have to offer the same benefit package to them as they offer to the "categorically needy." See Categorically Needy, Spend-down.

Medicaid Management Information System (MMIS)—A state's computer systems for tracking Medicaid enrollment, claims processing, and payment information. The 1996 HIPAA legislation requires that each state's MMIS have the capacity to exchange data with Medicare. It also contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions relating to the processing of health claims.

Medicare Buy-in—The informal term referring to the payment of Medicare Part B premiums on behalf of low-income Medicare beneficiaries who qualify for full Medicaid coverage (dual eligibles) or just for assistance with Medicare premiums and cost-sharing (Qualified Medicare Beneficiary, Specified Low-Income Beneficiaries, and Qualifying Individual).

Outstationing—The placement of state or local Medicaid eligibility workers at locations other than welfare offices. State Medicaid agencies are required to outstation workers at DSH hospitals and FQHCs to accept Medicaid applications from poverty-related pregnant women and children.

Primary Care Case Manager (PCCM)—PCCMs are physicians, physician groups, or entities having arrangements with physicians that contract with state Medicaid agencies to coordinate and monitor the use of covered primary care services by enrolled beneficiaries. State Medicaid contracts with PCCMs tend to be less comprehensive in their coverage of benefits and involve less financial risk than those with MCOs.

Prior Authorization—A mechanism that state Medicaid agencies may at their option use to control use of covered items (such as durable medical equipment or prescription drugs) or services (such as inpatient hospital care). When an item or service is subject to prior authorization, the state Medicaid agency will not pay unless approval for the item or service is obtained in advance by the beneficiary's treating provider, either from state agency personnel or from a state fiscal agent or other contractor.

Provider Tax—A tax, fee, assessment, or other mandatory payment required of health care providers by a state. States may use revenues from provider taxes to pay the state share of Medicaid spending only under limited circumstances specified in federal Medicaid law.

Qualified Medicare Beneficiary (QMB)—A Medicare beneficiary with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is at or below 100 percent of the federal poverty line (FPL) and whose countable resources do not exceed $4000. QMBs are eligible to have Medicaid pay all of their Medicare cost-sharing requirements, including monthly premiums for Part B coverage, and all required deductibles and coinsurance (up to Medicaid payment amounts).

Qualifying Individual (QI)—Between January 1998 and December 2002, States are required to pay all or a portion of Medicare premiums on behalf of a limited number of Medicare beneficiaries known as "Qualifying

Individuals," or QIs. Unlike other categories of low-income Medicare beneficiaries (e.g., dual eligibles, QMBs, and SLIMBs), QIs are not entitled to this assistance, but are enrolled on a first-come, first-served basis each year up to the limit established by each state' allotment of federal funds for this purpose. QIs have incomes from 120 to 175 percent of the federal poverty level (FPL) and countable resources of up to $4,000.

Rebate—The amounts paid by manufacturers to state Medicaid programs for outpatient prescription drugs purchased by the programs on behalf of eligible beneficiaries on a fee-for-service basis. Rebates are calculated on the basis of the average manufacturer price (AMP) for each drug and, in the case of brand name drugs, on the basis of the manufacturer's best price. A manufacturer must agree to pay rebates in order for federal Medicaid matching funds to be paid to states for the costs of the manufacturer's drug products. See Average Manufacturer Price, Best Price, Formulary.

Resources—Sometimes referred to as assets, resources are items of economic value that are not income. Resources include financial instruments such as savings accounts and certificates of deposit, personal property such as an automobile (above a specified value), and real estate (other than an individual's home). Some Medicaid eligibility groups must meet a resource test; others (at state option) are not subject to a resource test. In establishing a resource test, a state Medicaid program must specify both the resource standard (e.g., the amount of countable resources an individual may retain) and the resource methodology (e.g., which resources are counted and how are they valued).

Section 1115 Waiver—Under section 1115 of the Social Security Act, the Secretary of HHS is authorized to waive compliance with many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to "promoting the objectives of" the Medicaid program while continuing to receive federal Medicaid matching funds. In 2001, 19 states were operating Medicaid section 1115 waivers affecting some or all of their eligible populations and involving $27 billion in federal matching funds, or one fifth of all federal Medicaid spending that year. The waivers, which are granted (or renewed) for 5-year periods, are administered by CMS. See also Health Insurance Flexibility and Accountability Waivers.

Section 1915(b) Waiver—Under section 1915(b) of the Social Security Act, the Secretary of HHS is authorized to waive compliance with the "freedom of choice" and "statewideness" requirements of federal Medicaid law in order to allow states to operate mandatory managed care programs in all or portions of the state while continuing to receive federal Medicaid matching funds. The waivers, which are granted (or renewed) for 2-year periods, are administered by CMS.

Section 1931 Eligibility/Medicaid for Low Income Families (MLIF)—Under section 1931 of the Social Security Act, states must extend Medicaid eligibility to parents (and older children) in families who meet the eligibility requirements that were in effect under their state's Aid to Families with Dependent Children (AFDC) program as of July 16, 1996. States have the option under section 1931 to raise the eligibility levels for these parents through the use of "less restrictive" income and resource methodologies (see de-linking).

Single State Agency—The agency within state government designated as responsible for administration of the state Medicaid plan. The single state agency is not required to administer the entire Medicaid program; it may delegate most administrative functions to other state (or local) agencies or private contractors (or both). However, all final eligibility determinations must be made by state (or local) agency personnel.

Specified Low Income Medicare Beneficiary (SLMB)—A Medicare beneficiary with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is above 100 percent and not in excess of 120 percent of the federal poverty line (FPL) and whose countable resources do not exceed $4000. SLMBs, like QMBs are eligible to have Medicaid pay their Medicare monthly premiums, but unlike QMBsare not eligible for Medicaid payment for their Medicare cost-sharing obligations. See also Dual Eligible, Federal Poverty Level, and Qualified Medicare Beneficiary.

Spousal Impoverishment—The term used to describe the set of eligibility rules that states are required to apply in the case where a Medicaid beneficiary resides in a nursing facility and his or her spouse remains in the community. The rules, which specify minimum amounts of income and resources each spouse is allowed to retain without jeopardizing the institutionalized spouse's eligibility for Medicaid benefits, are designed to prevent the impoverishment of the community spouse.

State Medicaid Plan—Under Title XIX of the Social Security Act, no federal Medicaid funds are available to a state unless it has submitted to the Secretary of HHS, and the Secretary has approved, its state Medicaid plan (and all amendments to the state plan). The state Medicaid plan must meet 64 federal statutory requirements.

State Plan Amendment (SPA)—A state that wishes to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement rates must amend its state Medicaid plan to reflect the proposed change. Similarly, states must conform their state plans to changes in federal Medicaid law. In either case, the state must submit a state plan amendment (SPA) to CMS for approval.

Statewideness—The requirement that states electing to participate in Medicaid must operate their programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived under section 1115, 1915(b), and 1915(c) waivers.

Supplemental Security Income (SSI)—A federal entitlement program that provides cash assistance to low-income aged, blind, and disabled individuals. Individuals receiving SSI benefits are eligible for Medicaid coverage in all states except "section 209(b)" states, which have

opted to use their more restrictive 1972 criteria in determining Medicaid eligibility for SSI recipients. See Section 209(b).

Temporary Assistance for Needy Families (TANF)—A block grant program that makes federal matching funds available to states for cash and other assistance to low-income families with children. TANF was established by the 1996 welfare law that repealed its predecessor, the Aid to Families with Dependent Children (AFDC) program. Prior to this repeal, states were required to extend Medicaid coverage to all families with children receiving AFDC benefits. States may but are not required to extend Medicaid coverage to all families receiving TANF benefits; states must, however, extend Medicaid to families with children who meet the eligibility criteria that states had in effect under their AFDC programs as of July 16, 1996.

Third Party Liability (TPL)—The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary. For example, if a Medicaid beneficiary is also eligible for Medicare, the Medicare program is liable for the costs of that beneficiary's hospital and physician services, up to the limit of Medicare's coverage. From the Medicaid program's standpoint, Medicare is a liable third party. Other examples of TPL include private health insurance coverage, automobile and other liability insurance, and medical child support.

Title XIX—Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., is the federal statute that authorizes the Medicaid program. Related titles of the Social Security Act are Title IV-A (TANF), Title IV-E (Foster Care and Adoption Assistance), Title V (MCH block grant), Title XVI (SSI), Title XVIII (Medicare), and Title XXI (SCHIP).

Transfer of Assets—Refers to the practice of disposing of countable resources such as savings, stocks, bonds, and other real or personal property for less than fair market value in order to qualify for Medicaid coverage. When such transfers occur, it is usually in connection with the anticipated or actual need for long-term nursing home care. Federal law limits (but does not entirely prohibit) such transfers.

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Transitional Medical Assistance (TMA)—Refers to Medicaid coverage for families with children leaving welfare to become self-supporting through work. States are required to continue Medicaid benefits to families who lose their cash assistance due to an increase in earnings. The transitional coverage extends for up to 12 months as long as the family continues to report earnings.

Upper Payment Limit (UPL)—Limits set forth in CMS regulations on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans. Payments in excess of the UPLs do not qualify for federal Medicaid matching funds. The UPLs generally are keyed to the amounts that can reasonably be estimated would be paid, in the aggregate, to the class of providers in question using Medicare payment rules. In the case of MCOs, the UPL is specific to each plan and is tied to the amounts that would have been paid under Medicaid on a fee-for-service basis.

Vaccines for Children (VFC) Program—A program under which the federal government, through the Centers for Disease Control and Prevention, purchases and distributes pediatric vaccines to states at no charge and the state in turn arranges for the immunization of Medicaid-eligible and uninsured children through public or private physicians, clinics, and other authorized providers.

Waivers—Various statutory authorities under which the Secretary of HHS may, upon the request of a state, allow the state to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute. In the case of program waivers such as the 1915(c) waiver for home- and community-based services, states may receive federal matching funds for services for which federal matching funds are not otherwise available. In the case of demonstration waivers such as the section 1115 waivers, states may receive federal matching funds for covering certain categories of individuals for which federal matching funds are not otherwise available. Under Section 1915(b) waivers, states may restrict the choice of providers that Medicaid beneficiaries would otherwise have.